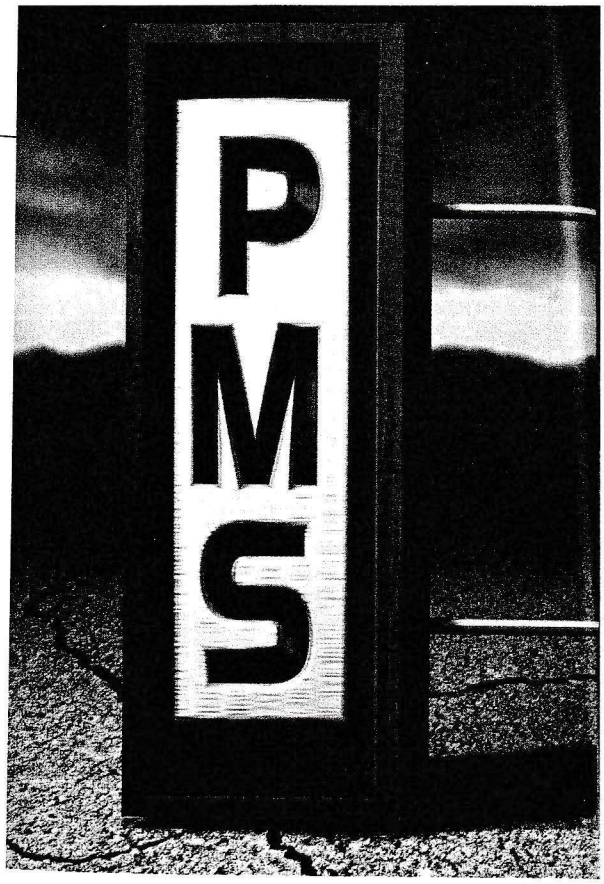

This is your pilot speaking

The national plan envisages that a third of all GPs will be on personal medical services contracts by 2002. But a study of pilot schemes reveals that not all are using the freedoms and flexibilities offered by the legislation. June Huntington and colleagues report

More than 2.5 million people are registered with first and second-wave personal medical services pilots, and 8 per cent of GPs work under a locally designed PMS contract.

The national plan proposes a major expansion of PMS contracts so that a third of GPs will be on them by April 2002 and more than half by 2004.

In 1998, the Department of Health commissioned Birmingham University to conduct a three-year study of 27 first-wave pilot schemes as part of its national PMS evaluation programme.

These sites are located in different parts of England and cover urban and rural locations and areas of differing affluence. They also cover a range of different organisational forms: single practices, groups of practices, and community trust-led schemes. Data from 14 sites has been studied in depth.

Levers for change

GP practice-based pilots welcome the reduction in the detailed paperwork necessitated by item-of-service claims under their former contractual arrangements. They have more time, as they dispense with the requirement to fill in and check these claims.

One practice manager has been able temporarily to work part-time in the practice and part-time in the local primary care group office. Another practice has re-trained its administrative staff to conduct audits that support the work of the GPs and nurses.

Some of the financial risks of running a practice have been removed. Under a localised contract with the health authority, practices receive regular monthly payments, paid in advance.

More importantly for the modernisation agenda, greater predictability of income flow tends to free GPs to reflect on what they do and how they do it. One lead GP said: 'As the funding is different, I am looking at things in different ways.'

Some are beginning to manage their workload more effectively. Three practice managers commented: 'They (GPs) have been able to work in different ways and a lot of stress has been removed. The atmosphere is different: there is less pressure on the GPs, so the staff are happy. They seem to have more time these days.'

Holding a practice-based – as distinct from individual GP-based – contract has reinforced perceptions of the practice as an organisation that can be proactive rather than simply reactive. Analyses of patient demand and consequent workloads are promoting new patterns of response that attempt to relate type of service more closely to the needs of particular groups of patients. These new patterns are also grounded in radical reviews of the range of skills and their use across the whole practice.

Practice nurses have taken on new and extended roles: some working to agreed protocols and

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Acting up: the legislation

The NHS (Primary Care) Act, passed in April 1997, two weeks before Labour came to power, allowed health authorities for the first time to commission primary care services from any local provider within the NHS family.

The term 'personal medical services' was used to distinguish those provided under the new act via a localised contract between a provider organisation and an HA, from general medical services provided under part two of the NHS Act 1977 via a nationally negotiated, individual GP contract.

Although a regulatory framework produced by the NHS Executive has been imposed on PMS pilots to ensure that local contracts share some similarities with the national GP contract, HAs and pilot sites are free to develop innovative clinical and organisational approaches to meet patients' needs. Pilots are also expected to benefit primary care professionals by providing new and flexible opportunities for employment and work satisfaction that would address problems of recruitment and retention of staff.

Other policy aims include improving equity of GMS resources. GMS funding was formerly tied to the GP principal as an independent contractor. If these GPs did not wish to establish themselves in areas of greatest need, GMS resources were lost to those areas. Under PMS contracts, equivalent GMS resources can go to areas with few doctors to appoint a salaried GP or nurse practitioners.

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holding minor illness clinics while others develop more specialised roles in family planning or the management of chronic diseases such as asthma or diabetes. Some are being encouraged to train and work as nurse practitioners.

Overall, changes in skill-mix have brought greater job satisfaction for GPs, which should contribute to improved recruitment and retention.

'The job is much nicer and you are practising proper medicine. I am seeing far fewer coughs, colds and sore throats,' says a non-lead GP.

'I do feel I have more control and am also not bogged down with the trivia,' another commented. 'When you have routine appointments not disturbed by emergencies, [it is] so much calmer. Every GP would be happier if they delegated more. What stresses out people is the unexpected... then the work piles on top of you.'

Changes in skill-mix change the role of GPs in other ways. They see more of the complex cases, and 'without the quick patient to catch up on it is changing the pattern and time of consultation rates'. Two of the PMS pilots plan to look at how they may change the styles of surgeries they offer to accommodate these changes.

The new funding flexibilities of PMS have made it easier for GPs to experiment with new forms of skill-mix in managing increased workload. One practice, for example, has decided not to take on a fourth GP partner, although its increased patient list size warrants it.

Instead, they will use the resources to employ a nurse practitioner and part-time GP. Just as GP co-ops improved night-time working conditions for GPs, the PMS policy initiative appears to improve day-time conditions.

Alongside the increased satisfaction experienced by many GPs, serious concerns were expressed. There had been delay in receiving the agreed inflationary uplift for year two, in comparison with their colleagues still working under GMS conditions. Some felt this was understandable as they were in a new scheme. Many also acknowledged that changes in staff at all levels – the NHS Executive headquarters, regional offices, and HAs – had not helped matters.

Lack of support from HAs was cited by a small number of pilots. As many PMS pilots are based on either the creation of new primary care organisations or the development or modification of existing ones, this is a major issue. Some organisations are quite fragile and appear to require considerable organisation development support, which has not been built into the pilots.

This is particularly the case in two community trust-led schemes. During the first year, we noted that the establishment of a new service in the trust-led schemes was taking much longer than planned. We also noted that knowledge of general practice among trust managers appeared to be limited and that this in turn affected implementation. In year two, both trust-led schemes had lost key staff – GPs in particular – which has understandably affected their progress. Trust-led schemes tend to operate in areas with very deprived and dependent populations, which make high demands on staff, and particularly on GPs. These raise questions of organisational development, peer support and mentorship that future trust-led PMS schemes may need to consider.

Key points

- **An evaluation of 14 personal medical services pilot schemes has found the GPs involved welcome the reduction in paperwork.**
- **The flexibility in funding of the schemes has allowed GPs greater leeway in managing their workload.**
- **Some of the financial risks of running a practice have been removed.**
- **It is questionable whether the schemes are fully using the freedoms envisaged.**
- **Some schemes reported a lack of support from their health authority.**

Feeling the tension

GP practice-driven pilots have also experienced tensions, particularly those which have created new organisational forms beyond the unit of the individual practice. In merged partnerships, like-minded practices have come together to form a new primary care organisation. The creation of a single management structure across three or more practices has challenged existing differences in values and patterns of work across practices. Resolution of such differences is not proving easy.

Changes in the respective roles of lead GPs and non-lead GPs, and of GPs and managers in these larger and more complex organisations, also tend to challenge inter-practice and inter-personal relationships. When these dynamics occur within the context of PCG development, as they have during the past year, relationships between pilots, PCGs and HAs are tested.

Whether or not the PMS providers are fully using the freedoms and flexibilities of the NHS (Primary Care) Act is questionable. But being a PMS pilot in many cases has stimulated and reinforced change and innovation. Pilot sites are improving access to primary care and extending the range of services they provide, developing the roles of GPs and nurses, and reorganising management responsibilities. Overall, GPs are enjoying greater job satisfaction while nurses are using their new opportunities to extend and develop their role. ●

'Changes in skill-mix have brought greater job satisfaction for GPs'

Next week: PMS relationships with primary care groups and health authorities.